California MEDICAL ASSOCIATION

NOTICES & REPORTS

PUBLIC RELATIONS

An Action Program for the California Medical Association

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***Chairman*, Committee on Public Relations**

YOUR PUBLIC RELATIONS COMMITTEE has spent many hours in a discussion of the basic problems and objectives of medical public relations, and of the methods and techniques by which a forward-looking program may be carried out.

The Committee has concluded that a fundamental problem of present day medical public relations, and indeed of medicine itself, is the challenge to freedom of choice and freedom of action of both doctor and patient which is posed by other than traditional forms of medical practice such as panel medicine, health center medicine, government medicine and compulsory health insurance. An effective modern policy and program must propose to meet this challenge.

A STUDY IN SAN FRANCISCO

Five years ago a study committee of the San Francisco Medical Society surveyed the literature on medical public relations and canvassed the membership of the society for its criticisms and constructive suggestions. Each of the data obtained by these means was classified by the committee into one of five categories as follows:

1. A lessened emphasis on the personal relationship between the doctor and his patient, or a breakdown in this relationship.

2. A public faith in the capabilities of modern medical science above and beyond what is warranted by the facts. This is in many ways comparable to Ponce de Leon's search for the Fountain of Youth, and views modern medicine as a precise science, capable of giving everlasting life. Many people believing this are determined that this shall be theirs. Disillusioned, they are often resentful.

3. Problems relating to medical economics.

4. The consequences of isolation and specialization within our profession. The increasingly specialized doctor, engrossed in his technology, has tended to withdraw from the community and even from his colleagues, with the result that the position of leadership and respect enjoyed by the traditional "horse and buggy doctor" may be forfeited, and one specialty within the profession may even be unaware of the problems of another.

5. Cumbersome, awkward or inadequate communications and administrative procedures within the society.

SOME BASIC FORCES IN OUR SOCIETY

The Committee recognized that certain powerful forces in our culture are at the root of the present-day challenge to freedom in medicine and to its public relations. These are inherent in the evolution of our democracy and are familiar to all.

1. Economic forces have resulted in increased costs, increased taxes, widespread deficit financing and the development of "fringe" benefits with the "third party" entering into the economics of medical care with its own interests to protect.

2. A fairly recent concept that the practice of medicine is essentially a commodity, consisting of diagnostic laboratory procedures, therapeutic pills, injections, operations and so forth, is held by many persons both within and without the profession. Accepting this concept, they logically believe that the practice of medicine should be handled as any other commodity and the techniques of mass production and mass distribution applied, as is done in the production and distribution of automobiles, for example.

3. The present day social trend which is shifting its emphasis from free enterprise toward the welfare state is of great importance. This force is very deep, very real, and fundamental to the challenge to freedom of action in medical care.

4. Political forces, because of the characteristics inherent in the democratic voting process, tend to move progressively in the direction of collectivism, and also to reflect the other forces described above.

THE DEFENSE TO DATE

The medical profession has instinctively opposed these trends as not being good for patients, doctors or the practice of medicine. What has been the defense to date?

1. In the economic field positive action has been taken in establishing Blue Cross, Blue Shield, other voluntary health insurance programs, relative value fee schedules, and the like. These measures, however, have not been adequate to meet the challenge. It seems unlikely that this basic challenge can ever be met with economic competition alone, because private medicine, by virtue of the individual physician's overhead, will probably always cost more than many forms of collective medical practice. Therefore, it is necessary that people be willing to pay more for the best medical care.

2. The defense against the concept of medical care as a commodity to be mass produced and mass distributed has been quite difficult. It turns upon such things as the art, as opposed to the science, of medicine, the importance of the doctor-patient relationship, and "better" medical care. These terms are poorly defined. Their meaning is vague. They have not been sold to the public, and the public, not understanding, cares little about them.

3. The defense against the social trend towards collectivism has been characterized by a nostalgic effort to return to the good old days. Emotional appeals have been used (Whitaker & Baxter), or the position taken that what is good for medicine is good for the public, an attitude similar to former Defense Secretary Wilson's, "What is good for General Motors is good for the country." The arguments used have depended heavily upon cliches such as "free choice" and "doctor-patient relationship" and our undocumented belief that private medicine is actually better for the patient.

4. In politics, the defense has been largely based on the quite effective use of pressure and persuasion in an effort to turn or at least to slow the tide. Legislators, special groups in the communities, and doctors themselves have been influenced. But the final analysis in terms of the basic challenge reveals a fatal weakness in this approach. The ultimate pressure weapon is the strike, and this will not be used. It is unthinkable to the profession; it would be unenforceable among doctors and would never be tolerated by the public. For these reasons the use of political pressure must be inadequate in any final test.

All of this presents a depressing picture. Many physicians believe that the political, social, economic and philosophic forces tending toward collectivism cannot be neutralized, and that it is only a matter of time until the socialization of medicine will occur. Others are more hopeful, feeling that the issue has yet to be decided.

SOME ASSETS

The Committee believes the present position can be strengthened to the point where the medical profession will be able to maintain what it believes to be the best form of practice for its patients. In the opinion of the Committee, some of the assets of this present position are as follows:

1. The quality of medical care rendered by California physicians is clearly an asset which should be evident to all.

2. Personal medicine is superior to various forms of collective medicine. But this must be demonstrated and the public convinced.

3. Many surveys show that people continue to want their own personal physician. Those who advocate other forms of medical practice must persuade them otherwise, and this is not always easy.

4. There is a fundamental desire for freedom present in every individual and this applies to a desire for freedom of action as far as his own

health is concerned. Basically he cares more about himself and his family than he does about any union or any collective notion.

5. Each doctor has a deep interest in the welfare of his patients and his fellow man. This, though sometimes lost sight of, is the basic drive which motivates physicians to undertake the study and practice of medicine. It is this interest of the doctor combined with the concern of the patient with his individual problems which results in the personal doctor-patient relationship.

6. It is a fundamental fact that in the long run what is best for the patient is always best for medical practice and for the doctor. This fact, too, has been lost sight of sometimes.

The Committee believes that if the basic challenge to freedom in medical care is to be met, the emphasis must be at the individual level. The individual chooses for himself, for his family, for his group, for his union or at the ballot box between personal medicine and some other form of medical practice. If the individual is convinced that private medicine is best, the political, social and economic aspects of the problem will work themselves out. A major asset lies in the fact that personal medicine can have its strongest influence at the level of the individual where the personal physician renders his personal service. Panel medicine and other forms of collective medicine are weaker at this point.

THE INDIVIDUAL IN OUR SOCIETY

It is appropriate to consider the position of the individual in our society in relation to medicine's public policy and public relations. Our democratic tradition holds that everyone is free and equal. But it is obvious that no one can be completely free and equally obvious that people are not all equal. In the evolution of our democracy the element of freedom has lost some of its impact and the element of equality, which is inherent in collectivism and in the desire for security, has gained strength. This was predicted more than a century ago by Alexis de Tocqueville. The principle of majority rule inherent in democracy tends to emphasize collective interests over those interests of the individual, which are different from the group. At the ballot box the voter often may choose only among alternatives presented by various pressure groups representing special collective interests. There is infrequently a pressure group or collective interest representing the voter's desire for personal and individual freedom. Consequently, over the years the trend is inevitably toward collectivism unless a neutralizing or opposing force is brought to bear.

But the nature of the individual does not change and the desire for individual freedom remains strong. History emphasizes this unceasing, dynamic struggle to achieve a balance and shows that each time collective security becomes too binding there is reversion or revolt towards freedom. The idea of freedom is particularly rooted in the history of our own nation. Together with security, it is a need of every individual. This desire for personal freedom is the force which must be mobilized and made strong enough to neutralize the trend toward collectivism in medical care.

THE ROLE OF THE PROFESSION

It would appear that organized medicine is in a strong position to champion the individual's desire for personal freedom, together with his need for security, particularly as it relates to his medical care. There is an established local, state and national organization. There is the long tradition of the doctor's personal interest in the individual patient. Indeed, this is the *raison d'etre* of the medical profession. It is the crux of the traditional doctor-patient relationship. Therefore it follows that if it is in the best interest of the individual to achieve a balance between his desire for freedom and his desire for security, both in solving his personal problems and in his need for medical care, then this must be the goal of his doctor. That which is good for the patient and that which is good for the medical profession are fundamentally identical.

It is noteworthy that under some conditions collective medicine is actually in the best interest of the patient. This occurs whenever what might be called "epidemic" conditions exist and the principle of the greatest good for the greatest number actually becomes the best interest of each individual under the circumstances. Historically organized medicine has without question entered into collective forms of medical practice when such "epidemic" conditions prevail. This occurs in military medicine with its threat of epidemic injuries, in civil defense programs, in public health where there is a threat of epidemic disease, and occasionally where groups of people are isolated from access to ordinary medical care.

But medical care problems in this country are normally "endemic," not "epidemic." Under the usual conditions the individual himself is the primary concern, personal medicine serves his interest better and the best result for each individual is not synonymous with the greatest good for the greatest number.

A PROGRAM OF MEDICAL PUBLIC RELATIONS

Under the present circumstances, and to meet the challenge to freedom of choice and freedom of action of both doctor and patient in medical practice,

the following concepts are suggested as fundamental to a timely program of public relations and public policy:

1. The personal character of our medical practice must be emphasized.

2. The doctor and the medical profession must be identified with the desire present in every individual for freedom of action, particularly in matters pertaining to his health and welfare.

3. The doctor-patient relationship, with its special concern with the individual as such, must be extended to public relations and to public policy. The doctor-patient relationship between organized medicine as physicians and the community as a group of individuals, must become a social reality.

4. The interest of the doctor and the profession in the individual must be extended to include his political, social and economic predicament as it involves his medical care. In each instance that which is best for the individual or for the groups of individuals under the existing circumstances should be supported.

5. The emphasis of public policy and public relations must be shifted from what is good for medicine to what is good for the public or good for the patient. Actually, in the long run, these are identical.

To illustrate the last points from the public relations standpoint, two recent examples are cited. The first emphasized medicine and the doctor's interest, and the second, the patient and his interest. During the recent legislative hearings on the Department of Social Welfare's Medical Assistance Program, several statements made by physicians gave rise to unfavorable editorial comment and antagonistic "letters to the editor." These physicians were quoted as having stated that the bill "subjugated medical personnel," "demeaned the physician's personal dignity," "degraded medical care to the lowest level," "deprived doctor of his soul-satisfying feeling that he is charitable," "third party medicine is a violation of our rights as physicians." Statements such as these, reflecting the attitude that what's good for medicine is good for the State, were received unsympathetically by the press and by the public.

On the other hand, the House of Delegates' Resolution No. 28, which dealt with basic medical rights for the individual, achieved prompt and wide acceptance. Within a few weeks, its principle was accepted by the American Medical Association House of Delegates and more recently, by the United States Senate. It is noteworthy that when the emphasis was on the doctor and his special interests, the result was a poor public reaction, and when the emphasis was on the patient and his interest, the result was good.

The Committee reviewed its capability for action in terms of this evaluation. It believes that it has a basic policy in the 1956 Public Relations Committee report which was approved by the House of Delegates. This report recommended that the public relations program of the California Medical Association should:

1. Emphasize the interest of the medical profession in the individual and strengthen the doctor-patient relationship.

2. Emphasize the capabilities and limitations of modern medical science and point out that it is not a commodity which can be mass produced and mass distributed but an individual service which is rendered on a personal basis.

3. Intensify the efforts of the profession in the field of medical economics with emphasis both on the patient's desire for freedom of action and his need for secure protection.

4. Continue the program to improve constantly the service rendered by individual physicians to their patients.

Realizing that public relations is essentially a problem in communications the Committee has considered both the internal and external communications of the California Medical Association. Internal communications with our individual members are carried out through *Newsletter*, CALIFORNIA MEDICINE, various programs and publications of the county societies, and the annual visit of the President or President-Elect to the component societies. The Committee also noted that the Councilors themselves are a valuable channel of communication with the membership. Consideration was also given to mechanisms for internal coordination of public relations policies and programs at California Medical Association level. External communications, by which is meant communications between the medical profession and the public, were discussed. Techniques for use in the doctor's office, by county societies and by the California Medical Association, were considered.

The Committee also has given attention to certain areas of needed study. In the present circumstances it is considered imperative that convincing arguments and objective data be developed to:

1. Substantiate the belief that personal medicine is better than collective medicine under "endemic" conditions.

2. Characterize the doctor-patient relationship and demonstrate its importance to a public which understands it poorly and is apathetic toward it.

3. Demonstrate the importance of freedom of action by the individual in his medical care in a way which will be convincing to a person who believes otherwise.

4. Differentiate clearly the advantages of group medicine which is recognized and approved within the framework of organized medicine from the disadvantages of closed panels, which are not.

IMPLEMENTATION OF A PUBLIC RELATIONS POLICY

The implementation of a public relations policy consists of good performance both on the part of the individual physician and on the part of each component of organized medicine. This good performance includes the practice of the best medicine and also an *esprit de corps* in the profession, good public performance, sound policy, good leadership, effective communications, internal and external educational programs and a thousand other things. It includes every event in every doctor's office. It includes every action or inaction of every medical society. It includes every public utterance of every physician whether it is official or unofficial.

IN SUMMARY

The historic forces toward collectivism and security are frighteningly strong. The balancing force, the desire of the individual for his freedom, is relatively latent and unchampioned. Each individual and each group in the history of human civilization has tried to balance the needs for freedom and for security. The doctor helps his patient achieve this balance in his personal problems in terms of his capabilities and disabilities. This interest must now be extended to include the problems of the individual in matters pertaining to his medical care in relation to modern political, economic and social pressures.

The doctor and organized medicine must extend this traditional doctor-patient relationship to help the individual as a voter to balance the ideals of freedom and security in medical care and must act as physician to the community in accomplishing this. Such activity can be an expression of the deeply powerful and emotional drive in each doctor to serve the best interests of his patient, whatever may be his circumstances. A successful program of public policy and public relations must be an expression of this traditional concern with every individual who is or may become the patient, as distinguished from the collective concept of medical practice as a tangible commodity suitable for mass distribution, which at best, can only achieve the collective goal of the greatest good for the greatest number, which might or might not happen to include any individual patient.

A Statement on Newspaper Reports on a Study of Hospitals

A statement of the California Medical Association, presented in its behalf by Howard Hassard, CMA legal counsel, before the Subcommittee on Hospitals of the Assembly Committee on Public Health. San Francisco, August 30, 1958.

Mr. Chairman and members of the Committee:

The California Medical Association is glad to meet with you for a discussion of recent news reports which have indicated to you the possible need of looking into the practices of some physicians and some hospitals in California.

The California Medical Association is a nonprofit membership association, in which membership is voluntary. The Association is made up of a federation of 40 county medical societies in the state, each of them autonomous in its own actions and decisions. The Association, in turn, federates with other state and territorial medical associations to form the American Medical Association.

The purposes of the Association are clearly set forth in its Constitution. They are enumerated as "to promote the science and art of medicine, the protection of the public health and the betterment of the medical profession; to promote similar interests of its component societies . . ."

The clear language of these constitutional provisions has been rigidly followed for the past 102 years.

Constantly seeking improvement, the CMA several years ago embarked on a series of studies of the relationships between physicians and their patients. We sought to learn why some patients are happy and enthusiastic in their relationships with their own physicians and others are not.

These studies were undertaken as the groundwork for seeking the causes for medical malpractice actions that have been finding their way into our courtrooms in increasing numbers and severity in the past decade or so. The cost of these actions has been high but, more important, there is the underlying question of why such actions should ever arise in the first place. If the correct answer can be found to that question, the welfare of all will be materially benefited.

We have long recognized that medical malpractice actions are in some measure what we call "poor public relations gone to court." Since each such action represents a patient on one side and a physician on the other, we must get down to the original point of contact between a patient and a doctor.

To start from this point the Association has called upon various of its regular and special committees to study the relationship between physicians and

patients. It has also retained outside consultants, including technical services by Stanford Research Institute. In fact, the CMA has spent in cash $178,157 in this endeavor during the past three years.

The first such study (1955) was made in the form of an analysis of physicians who had had malpractice suits filed against them. Contrasted with these physicians was a control group of physicians in comparable situations who had not had such suits. This pilot study—called the San Mateo Project—led to further research.

Another study was made on patients who had been plaintiffs in malpractice actions, contrasted with a control group of patients who had not been involved in such litigation. A summary of this study was published and sent to each county medical society and to each member of the Association. We have now distributed 20,000 copies of this summary.

More recently, and simply because there was evidence to show that some 70 per cent of malpractice actions arose from patients who have been hospitalized at the time of the alleged incident, we have sought to find out what happens in some hospitals that results in a high incidence of such actions. For the motivational research scientist to work it is necessary for him to use known contrasts or extremes. Thus four hospitals with the highest malpractice rates were selected to be compared with four hospitals with the lowest malpractice rates. Scientifically speaking, it would have been a surprise if the research had not disclosed strong contrasts.

These studies have been made by consulting psychologists. Prior to the current study, the research team prepared a written report and submitted it—for critical comment—to a panel of distinguished scientists in the humanities. After their revisions, the final report was prepared and submitted to the CMA. The most recent study was sent to the Board of Review a brief fortnight ago. Almost immediately a Scripps-Howard reporter commenced publication of excerpts—mostly from pages 149-150 of a 341-page document. It is this most recent study which has found its way into the press even before the appropriate committee of the CMA has had a chance to review and evaluate it.

The CMA has long realized that studies of this nature constitute in each instance a fragmentary part of an overall study which by its very nature must be on a long-term basis. The current report, together with a number of other reports, must be calmly appraised and evaluated. Its findings must be fitted together with other findings. Its validity must be established and its relative importance assayed before a mature and sound conclusion can be reached upon which the CMA might institute a program to improve any conditions found to be anything less than desirable.

It is unfortunate that the press stories which have appeared—and which have caused your committee to gather today—have been pretty much restricted to a few verbal, unverified items.

CASE IN POINT—The San Francisco *News*, Tuesday, August 26, 1958, carried this banner headline "SECRET HOSPITAL REPORT—DOCTOR HATED KAISER SO LET A MAN DIE." Such a statement is unbelieveable to any thinking person. Its accusation is so abhorrent that it demanded above all else an immediate investigation of the facts.

Here are the facts:

In the report, on page 149, a reference to Hospital "F-2" contains a series of anonymous statements, unidentified in the report as to source. In fact, the authors, on page 146, say:—"Informal Reports—During the course of the research, a good number of informal comments . . . unsolicited information, came to the attention of the investigators. Ordinarily, such materials are considered to have questionable value. . . . As with other verbal material we cannot authenticate what is said. . . ."

One of the anonymous accusations freely quoted in the press is that a physician on emergency duty at F-2 hospital found that an accident victim belonged to a closed panel health plan, that the physician hated the particular plan so he had the patient put back in the ambulance and sent to the closed panel hospital, a few miles away, and the patient was dead on arrival. Although the report is anonymous and although the California Medical Association did not know the names of the hospitals studied, it was possible from the newspaper information to determine the general location of Hospital F-2.

Examination of public records at the courthouse in Martinez, discloses the case of Black vs. Wise. This lawsuit was started in February, 1956, and was tried before Judge Wakefield Taylor and a jury, about two months ago. The facts—the plaintiff alleged wrongful death; Black, a 29-year-old white male steelworker some time after leaving work drove his auto into a tree; was severely injured and was taken by ambulance to the emergency room of a nearby hospital. Dr. Wise was in attendance. After examination, and disclosure by Black that he belonged to a nearby medical panel plan, Dr. Wise had him put back into the ambulance and sent to the plan's hospital in the same county. He was dead on arrival. In the trial it developed that Black had a severe head injury, that Dr. Wise, a general practitioner, was not trained in brain surgery, that Dr. Wise thought the panel hospital did have a specialist for this type of injury, that the patient was sent to the panel hospital because of these facts and that Dr. Wise had no prior anticipation that he would not survive the journey. The Coroner's death cer-

tificate reads, "cerebral contusions—pulmonary edema—alcoholism." The result: The jury voted 11-1 to exonerate the doctor.

Regardless of the result of the lawsuit, one wonders why these facts could not have been checked. Just a few weeks ago, the public press in Contra Costa County fully reported the trial of the case.

In the past few days, the California Medical Association offices and county medical society offices have had inquiries from members of the public indicating anxiety and querying us about what action medical societies take to protect the public.

Medical societies constantly strive to maintain higher standards amongst their members and to discipline those found wanting. In fact in the same county to which I have previously referred, the Alameda-Contra Costa Medical Association, after formal hearing, expelled a physician for conduct detrimental to the welfare of his patients. This physician then sued the Association. The case was tried in Martinez and the Association's action upheld. It was then appealed to the higher courts and the Association's action again was upheld in part and modified in part. This case dragged through the courts for years and was just recently concluded. There are two sides to the coin—the Alameda-Contra Costa Medical Association to maintain high ethical standards spent thousands of dollars in legal costs, but to its credit it persevered.

Right now in Central California an entire medical staff of a hospital is being sued. Why? After extensive study it decided that one of the physicians on the staff was inadequately trained to perform the surgical procedures that he undertook. On the staff recommendation he was dropped from the staff. The result: Everybody is now sued and facing expensive, lengthy litigation.

As attorney for medical societies, may I emphasize that remedial action can only be taken after thorough investigation. It is easy for nonresponsible third parties to say "throw the rascals out" but our law protects property and personal rights. Due process means one is innocent until proven guilty. Again as attorney for the societies, it is my duty to advise against hasty actions or actions based on personality rather than on facts or on conclusions derived from anonymous claims unsupported by provable facts. Within the framework of law, all charges, anonymous or otherwise, found in the research team's report will be investigated and if the facts warrant, prosecuted.

It is the position of the California Medical Association that all studies into the physician-patient relationship should be made on a calm and professional basis as a means of establishing grounds for bettering the medical care available to the patient. If these research studies cannot be carried out in an atmosphere of confidence it is obvious that such studies cannot be made.

Psychological research into the behavior patterns of patients and physicians is not the sole effort of the California Medical Association in the field of malpractice suits. In cooperation with the State Bar, the California Medical Association has instituted, developed, and is actively encouraging local medical expert panel systems, under which independent and qualified physicians on a voluntary basis will consult with and advise attorneys having clients who have a grievance against a physician. This system, jointly sponsored by the State Bar and the California Medical Association, is described in articles published in the State Bar's *Journal* and in CALIFORNIA MEDICINE, the California Medical Association's publication, in February of this year. It received widespread commendation in the public press. It is in actual being in Los Angeles County; it is in the process of establishment in San Diego, Alameda and San Francisco Counties. While it is new and experimental, the California Medical Association sincerely hopes that time will prove its worth and that the public interests will be served.

In summation, the California Medical Association and its component county societies now recognize and for some years have recognized the need of constantly improving medical standards; have made numerous and costly investigations into means of improving such standards; have maintained a disciplinary system under which erring members may be subjected to professional punishment; have set up panels of physician experts to serve in lawsuits filed against their own members; in short, have devoted their efforts to a continuing program of self-improvement designed to benefit the patient.

The Joint Commission on Accreditation of Hospitals has for many years formulated standards for hospital accreditation. Should a careful review of the findings of this current study indicate the need for additional standards to be set up or more extensive inspection to be provided, the California Medical Association pledges that it will enthusiastically cooperate with the California Hospital Association and the Joint Commission on Accreditation to draft additional standards and safeguards that may be indicated.

We readily recognize the public interest which your committee represents and your natural desire to look behind the smoke and try to locate any flames. If in your wisdom your committee decides to look more closely into these matters, the California Medical Association stands ready to offer you every cooperation and assistance at its command.

Certified Psychologists

ON AUGUST 18 of this year, the California Board of Medical Examiners certified 508 psychologists in this State. This was carried out under Chapter 6.6 of the Business and Professions Code which became effective in September, 1957.

This certification represents the culmination of many years of discussion between committees of the California State Psychological Association (CSPA) and the California Medical Association (CMA) on the role of psychologists in California.

Since World War II, there has been a sizable increase in the number of psychologists trained for teaching, for research, for work in schools and industry, and for clinical practice. In two fields, industrial and clinical, the growth has been more pronounced. Industry has turned to psychologists for professional counsel on the application of psychological principles to the selection, utilization, development and coordination of human resources; for personnel and consumer research.

The shortage of psychiatrists, coupled with the need and demand for the particular training and skills of clinical psychologists, has led to increased utilization of them in hospital and other clinical settings. Their role generally involves diagnostic testing, individual counseling and group psychotherapy. A relatively small number of clinical psychologists are engaged in the private practice of counseling, clinical testing and psychotherapy.

The increase in demand for services has also led to the appearance of many unqualified persons calling themselves psychologists, often without adequate training, some with credentials from "diploma mills." Both the medical profession and the well trained ethical psychologists have been alarmed at the absence of control over these unqualified persons and absence of regulation of their activities, even when obviously harmful to individuals seeking their counsel.

The many discussions of CMA and CSPA committees led to introduction of a certification measure that would indicate clearly which persons have had adequate training, and that would certify qualified psychologists. While many psychologists, particularly those in academic (teaching), research, school or industrial settings, are not involved in medical matters, it was agreed that the public would best be protected by having all psychologists certified by the Psychology Examining Committee under the Board of Medical Examiners. This would not interfere in any way with the qualified psychologist in whatever field he might be working, but would offer controls over those psychologists engaged in private practice of counseling and psychotherapy.

The legislation spelled out the education and training requirements for certification as a psychologist: a Ph.D. degree in psychology from a recognized university and three years of approved clinical practice, or an equivalent as defined under the Code and determined by the Psychology Examining Committee.

Since 1951 referrals to psychologists for psychotherapy or other services for which psychologists are qualified by training and experience has been lawful (Business and Professions Code, section 2013). However, the legal medical responsibility for the welfare of the patient continues to rest with the referring physician.

The certification legislation, thus, in no way conflicts with the Medical Practices Act. . . ."Nothing in this chapter shall be construed as permitting . . . the administration or prescription of drugs, any infringement upon the practice of medicine as defined in the laws of this State or the use of therapeutic measures in the diagnosis or treatment of the mentally ill except in collaboration with a physician and surgeon as specified in Section 2013 of this Code."

Under the Certification Act, the practice of psychology is defined as "the application of established principles of learning, motivation, perception, thinking, and emotional relationships to problems of personnel evaluation, group relations, and behavior adjustment, by persons trained in psychology. The application of said principles includes, but is not restricted to, counseling and the use of psychotherapeutic measures with persons or groups with adjustment problems in the areas of work, family, school, and personal relationships; measuring and testing personality, intelligence, aptitudes, emotions, public opinion, attitudes, and skills; and doing research on problems relating to human behavior" (Business and Professions Code, section 2903.5).

As of January 1 of this year, only persons with qualifying credentials are allowed to use the title of *Certified Psychologist.* Thus, of the original 1800 who filed under the Act, nearly 900 will be *uncertified.* The uncertified may continue to call themselves psychologists (but *not* certified psychologists) under 2933.5 of the Business and Professions Code until 1965, which gives them seven more years to qualify for certification.

Only *Certified Psychologists* will be listed in the Directory of the Board of Medical Examiners. Of the initial 508 Certified Psychologists, 217 are in academic settings (such as teaching, school psychologists and research in universities) 146 are in other institutional settings (such as Veterans Administration and Civil Service); 48 are in industrial settings; and 97 are in private practice, mostly in the areas of concentrated population.

The Psychology Examining Committee and the Mental Health Committee of the C.M.A. have been

meeting regularly and plan further meetings to promote mutual understanding and effective working relationships for their respective professions. Any problems which may emerge will, under this arrangement, receive joint attention.

Council Meeting Minutes

Tentative Draft: Minutes of the 440th Meeting of the Council, San Diego, El Cortez Hotel, September 13 and 14, 1958.

The Council met on September 13, 1958, in the El Cortez Hotel, San Diego, for an informal discussion of basic philosophies and principles, such as consideration of such phrases as "free choice of physician," "third party" and other items which enter into current discussion of socio-economic problems. This day-long session was not recorded and minutes were not prepared on the informal discussions which took place.

Official minutes of the September 14, 1958, meeting follow:

The meeting was called to order by Vice-Chairman Sherman in the El Cortez Hotel, San Diego, on Sunday, September 14, 1958, at 9:00 a.m.

Roll Call:

Present were President West, President-Elect Reynolds, Speaker Doyle, Vice-Speaker Heron and Councilors MacLaggan, Wheeler, Todd, Foster, O'Neill, Kirchner, O'Connor, Shaw, Pearman, Harrington, Davis, Sherman, Bostick and Teall.

Absent for cause: Councilor Lum, Secretary Daniels and Editor Wilbur.

A quorum present and acting.

Present by invitation during all or part of the meeting were Messrs. Hunton, Thomas, Clancy, Gillette, Whelan and Collins of C.M.A. staff; Messrs. Hassard and Huber, legal counsel; Messrs. Read and Salisbury of the Public Health League of California; county society executives Scheuber of Alameda-Contra Costa, Jensen of Fresno, Geisert of Kern, Pettis and Field of Los Angeles, Marvin of Riverside, Foster of Sacramento, Donmyer of San Bernardino, Nute of San Diego, Neick of San Francisco, Donovan of Santa Clara, Dermott of Sonoma and Grove of Monterey; Messrs. Wahlberg and Lyon and Doctor William Gardenier of California Physicians' Service; Doctor Malcolm Merrill, state director of public health; Doctor John Keye, medical director of the State Department of Social Welfare; Doctor Dan O. Kilroy, legislative chairman; and several physicians representing, as officers or council members, county societies in Santa Clara, Riverside, Kern, San Bernardino and San Diego Counties.

1. *Minutes for Approval:*

On motion duly made and seconded, minutes of the 439th Council meeting, held August 16, 1958, were approved.

2. *Membership:*

(a) A report of membership as of September 10, 1958, was presented and ordered filed.

(b) On motion duly made and seconded, 15 delinquent members who had met their dues obligations were voted reinstatement.

(c) On motion duly made and seconded in each instance, two applicants were voted associate membership. These were: Margaret R. Leftwich, Santa Clara County, and A. C. Atwood, Stanislaus County.

(d) On motion duly made and seconded, it was voted to reduce the dues of one applicant because of illness.

3. *Financial:*

(a) A report of bank balances as of September 10, 1958, was presented and ordered filed.

(b) Chairman Heron of the Finance Committee reported that the Association must plan for funds needed to complete the purchase of a headquarters building next July 1. He also asked that the Council give additional thought to financial demands for the establishment of a department of research, which would require an increase in dues.

4. *Commission on Medical Services:*

(a) *Rehabilitation:* The Committee on Rehabilitation presented a statement and guide for the assistance of county medical societies in establishing their own machinery to deal with rehabilitation problems. Upon approval of this statement and guide, the committee proposed to send copies to the county societies. On motion duly made and seconded, it was voted to approve the statement and guide and to forward copies to the county societies.

(b) *Public Welfare:* Doctor Leslie B. Magoon and associates, representing the Santa Clara County Medical Society, requested the Council to approve a plan suggested by the county society under which an indemnity type of payment for medical services rendered under the public assistance medical care program would be instituted. On motion duly made and seconded, it was voted that the Council approve and support the effort of the Santa Clara County Medical Society to establish its proposed indemnity pilot program in the California public assistance medical care program.

Discussion was held on the advisability of publishing the results of a poll taken of Association members several months ago as to their preferences for a uniform method of payment for services provided under the public assistance medical care program. On motion duly made and seconded, it was voted to adopt the following statement:

"Careful review of experience developing since the poll was taken suggests that the development of a uniform method of payments must be consistent with the development of pilot programs and local control on the county level as required by *Resolved* No. 3 of House of Delegates Resolution No. 1. The poll is inconsistent with this point of view. We therefore recommend that a new poll of the membership be organized on a county basis as desired by each county society concerned.

"In the light of subsequent developments the existing poll is inadequate.

"Pending the completion of such a subsequent poll, the existing poll shall guide deliberations of the C.M.A. Council and committees."

Doctor John Keye, medical director of the State Department of Social Welfare, reported that audits of medical bills under the public assistance medical care program would be carried out through California Physicians' Service review boards in those counties where C.P.S. acts as fiscal administrator. In other counties, the county societies will be called upon by local welfare directors to establish suitable review boards.

5. *Commission on Professional Welfare:*

Doctor Kirchner, chairman of the Medical Review and Advisory Board, suggested that Resolution No. 14 of the 1957 House of Delegates be referred to the Liaison Committee to the State Bar of California. On motion duly made and seconded, it was voted to so refer.

Doctor Kirchner reported that the American Hospital Association had requested the cooperation of the Medical Review and Advisory Board in producing and distributing a film on medical malpractice. The Board has approved this request and will report to the Council on later developments.

Mr. Fred Field, legal counsel to the Los Angeles County Medical Association, reported on a study being made on a claims prevention program which would utilize committees of the society. Further reports will be made on this study.

Doctor Kirchner reported that a subcommittee of the Board, consisting of Doctors William F. Quinn, William Kaiser and James Yant had been appointed to make a thorough study of a report recently received from a psychological consultant and report back to the Board. On motion duly made and seconded, it was voted to approve this subcommittee.

On motion duly made and seconded, it was voted to refer to the Committee for Emergency Action several communications which had been received from parties interested in the psychological report.

On motion duly made and seconded, the following resolution was adopted:

Resolved: That the Council request:

(1) The Committee for Emergency Action meet with the hospital staff of the Pittsburg Community Hospital.

(2) The newly appointed subcommittee of the M.R.A.B. immediately go into the facets of the Blum report and make their recommendations for future action on this report to the M.R.A.B. and the Council.

(3) The Council, through its president, Dr. West, make overtures to the California Hospital Association to form a joint committee to study this and other problems regarding doctor-hospital relations.

6. *Commission on Public Health and Public Agencies:*

Doctor Bostick reported that the budget of the State Department of Public Health now under preparation would include funds for work on radiation hazards.

Doctor Bostick proposed that Doctor Chester Barta of San Diego be named as the Association's representative at the forthcoming Governor's Conference on Traffic Safety. On motion duly made and seconded, this nomination was approved.

Doctor Bostick also reported that the Crippled Children's Service was considering the addition of epilepsy as a disease entity coming under the service's program. A subcommittee of the Advisory Committee to Crippled Children's Service is now studying this proposal and, on motion duly made and seconded, it was voted to consider the recommendations of this subcommittee before the Council adopts a policy.

7. *Committee on Nominations:*

Doctor Bostick, as chairman of the Nominating Committee, recommended that Doctor Stuart Knox be appointed a member and chairman of the Committee on Mental Health. On motion duly made and seconded, this appointment was voted.

Doctor Bostick also proposed that Doctors C. Morley Sellery of Los Angeles, J. P. Conrad, Jr. of Fresno and William C. Chiapella of Chico (Sellery, chairman) be appointed as a liaison committee to the California Teachers' Association. On motion duly made and seconded, these appointments were approved.

8. *Commission on Public Policy:*

(a) Mr. Ed Clancy gave a progress report on activities of the Committee on Public Relations and its department.

On motion duly made and seconded, the Council voted the following resolution:

WHEREAS, Glenn Gillette has served the California Medical Association ably and well after having been executive secretary of the Fresno County Medical Society; and

WHEREAS, Glenn has been selected as one of the field representatives of the American Medical Association; and

WHEREAS, his services will continue to be available to the medical profession, so that the California Medical Association's loss is the American Medical Association's gain; now, therefore, be it

Resolved: That the Council of the California Medical Association express to Glenn Gillette its best wishes for his happiness and success in his new appointment and its thanks for his valuable services to the California Medical Association.

(b) Doctor Dan O. Kilroy, chairman of the Committee on Legislation, suggested that representatives of the legislative committee attend meetings with hospital representatives on matters raised by a recent psychological study.

On motion duly made and seconded, it was voted to invite Doctor J. Lafe Ludwig, a member of the legislative committees of both the C.M.A. and A.M.A., to attend Council meetings and make reports on national legislative matters.

Mr. Hassard reported that a meeting had been held with representatives of the American Cancer Society, California division, relative to legislation to provide cancer control measures.

Doctor Kilroy reported that a committee of state officials had recommended that standardized fees be adopted and paid by all departments of the state government which pay for medical care for individuals. Under the proposal the Relative Value Studies would be used, with a $3.50 factor for the surgical and a $4 factor for other sections. On motion duly made and seconded, it was voted that the C.M.A. recommend to the State Department of Finance the concept of paying the going rates as determined by current usual fee surveys by county units, with due consideration of the nature of the program to be served.

On motion duly made and seconded, it was voted that each county society be asked to advise the Association on what basis it considers that fees for the county area should be based, whether an average fee, median, model or third quartile.

9. *California Physicians' Service:*

Doctor Heron reported that California Physicians' Service now has 753,000 beneficiary and 13,798 physician members.

10. *Proposal for Research Department:*

Doctor West reported for an ad hoc committee which considered the advisability of establishing a research department within the Association. Discussion resulted in several amendments to the committee's report, which, on motion duly made and seconded, was approved as amended.

11. *Annual Session:*

A report of the Committee on Scientific Work, outlining some of the plans for scientific meetings at the 1959 Annual Session, was presented and approved as a progress report. The Council also voted on two proposed scientific exhibits on which the Committee on Scientific Work has sought Council advice.

12. *California Pharmaceutical Association:*

On motion duly made and seconded, it was voted to approve a request from the California Pharmaceutical Association for appointment of a liaison committee for the discussion of problems of mutual interest and to name the Committee on Other Professions as the body to form such liaison.

Time and Place of Next Meeting:

The chairman announced that the next Council meeting would be held in San Francisco on Saturday, October 11, and the November meeting in Disneyland on Saturday, November 8, 1958.

Adjournment:

There being no further business to come before it, the meeting was adjourned at 5:45 p.m.

SAMUEL R. SHERMAN, M.D., *Acting Chairman*
JOHN HUNTON, *Acting Secretary*

PROPOSED CONSTITUTIONAL AMENDMENTS

Five proposed amendments to the Constitution of the California Medical Association were presented at the 1958 House of Delegates. Under the terms of the Constitution, these proposed amendments must lie on the table for one year, or until the next regular session of the House of Delegates. Meanwhile, they must be published at least twice, in separate issues of the official journal.

All members of the Association, and especially the members of the House of Delegates, will thus have the opportunity to review these proposals during the coming year. They will be presented to the 1959 House of Delegates for vote, on which a two-thirds affirmative vote of those Delegates present and voting is required for passage.

SECRETARY-(TREASURER)

Constitutional Amendment No. 1.
Author: Donald D. Lum.
Representing: The Council.

Resolved, That Article VI, Section 1, of the Constitution be amended by deleting the term "-Treasurer" from the present term "Secretary-Treasurer" so that the named officer shall be known as "Secretary."

* * *

REPRESENTATION IN HOUSE OF DELEGATES

Constitutional Amendment No. 2.
Author: Sam J. McClendon.
Representing: Constitution Study Committee.

Resolved, That Article III, Part A, Section 2, of the Constitution of the California Medical Association be amended by deleting the words shown in parentheses below, so that the section shall read as follows:

Section 2—Representation

As the By-Laws shall provide, each component society shall be entitled to proportionate representation in the House of Delegates (but with a minimum of two delegates).

* * *

REPRESENTATION ON THE COUNCIL

Constitutional Amendment No. 3.
Author: Sam J. McClendon.
Representing: Constitution Study Committee.

Resolved, That Article III, Part B, Section 9, of the Constitution be amended in subparagraph (a) by deleting the words shown in parentheses below and adding the words shown below in italics, so that subparagraph (a) shall read as follows:

(a) Each Councilor District, as specified in this Constitution, shall be entitled to one Councilor for each 1,000 *active* members, *or major fraction thereof,* according to its membership as of the first day of (November) *September* of the preceding year; provided that each Councilor District shall be entitled to a minimum of one Councilor.

* * *

DELEGATES FROM SECTIONS

Constitutional Amendment No. 4.
Author: A. B. Sirbu.
Representing: San Francisco Medical Society.

WHEREAS, The scientific sections constitute an important part of the structure of the C.M.A.; and

WHEREAS, The sections are not represented in the legislative body of the C.M.A., the House of Delegates; and

WHEREAS, The sections of the A.M.A. have for many years been represented in its House of Delegates; and

WHEREAS, Each section of the C.M.A. has much to contribute toward policy making, both in the scientific and the economic phases of medicine; now, therefore, be it

Resolved, That each section of the C.M.A. be entitled to send one delegate with full voting rights to the House of Delegates of the C.M.A.; and be it further

Resolved, That the C.M.A. Constitution be amended to allow for such representation as follows: Article III, Section 1 amended by the addition of (e) Delegates elected by each scientific section as listed in Chapter IV, Section 1-a of the By-Laws.

* * *

CONSIDERATION OF CONSTITUTIONAL AMENDMENTS

Constitutional Amendment No. 5
Author: W. S. Lawrence.
Representing: Butte-Glenn Medical Society.

WHEREAS, Any amendment to the Constitution should be for the greatest good of the Association; and

WHEREAS, The most recent amendment to the Constitution which eliminates the Councilors-at-Large was passed without prior hearings in the appropriate reference committee during any regular session of the Association; and

WHEREAS, This action has denied interested delegates the opportunity to meet, exchange views, discuss the ramifications and evaluate the appropriateness of the Amendment to meet its purpose; and

WHEREAS, The proponents of the amendment would be the last to feel the necessity to press such an action through the House of Delegates without adequate consideration; now, therefore, without prejudice to the previous amendment, be it

Resolved: That Article VIII, Section 3, Paragraph 2 of the Constitution be amended by addition of the following:

"Further, such proposed amendment or amendments shall be referred to the appropriate Reference Committee who shall hold hearings on the proposed amendment or amendments during the course of its regular business while the Association is in convention. If the proposal or proposals are introduced during the first session of the House, hearings shall

be held at both the current and the next regular meeting. If the proposal or proposals are introduced during the second session, hearings shall be held at the next meeting, and in either event, prior to submission to the House of Delegates for vote.

BY-LAW AMENDMENT OFFERED

One By-Law amendment was offered at the April session of the House of Delegates by Reference Committee No. 4, the committee to consider proposed amendments to the Constitution and By-Laws. Since all proposed amendments to the By-Laws are required to lie on the table for 24 hours before being acted upon, this amendment must await the next regular session of the House of Delegates before it can be voted upon. The proposed amendment to the By-Laws reads as follows:

AMENDMENT TO BY-LAWS

By-Law Amendment No. 1.
Author: J. B. Price.
Representing: Reference Committee No. 4.

Resolved, That Chapter VII, Section 1, of the By-Laws be amended as follows:

First, delete subsection (b) and insert

"(b) *Commission on Public Health,* responsible for the activities of and through which the following standing committees shall report:

1. Committee on Rural and Community Health,
2. Committee on School Health,
3. Committee on Mental Health,
4. Committee on Industrial Health.

"(c) *Commission on Public Agencies,* responsible for the activities of and through which the following standing committees shall report:

1. Committee on Military Affairs and Civil Defense,
2. Committee on State Medical Services,
3. Committee on Veterans Affairs,
4. Committee on Other Professions,
5. Committee on Blood Banks,
6. Committee on Allied Health Agencies.

Secondly, re-letter the following subsections from (c) to (d) through (l).

Except as herein amended, said Chapter VII, Section 1, shall remain unchanged.

In Memoriam

EXTER, DONALD J. Died in Pasadena, September 20, 1958, aged 39. Graduate of the University of Southern California School of Medicine, Los Angeles, 1943. Licensed in California in 1943. Doctor Exter was a member of the Los Angeles County Medical Association.

✤

FERREE, ARTHUR C. Died in Fullerton, September 4, 1958, aged 40, of heart disease. Graduate of the University of California School of Medicine, Berkeley-San Francisco, 1943. Licensed in California in 1947. Doctor Ferree was a member of the Orange County Medical Association.

✤

LEMERE, HENRY BASSETT. Died at Laguna Beach, October 6, 1958, aged 86. Graduate of the University of Nebraska College of Medicine, Omaha, 1898. Licensed in California in 1927. Doctor Lemere was a retired member of the Los Angeles County Medical Association and the California Medical Association, and an associate member of the American Medical Association.

✤

MERRILL, RALPH E. Died in Glendale, September 2, 1958, aged 63, of hepatic failure. Graduate of Harvard Medical School, Boston, Massachusetts, 1920. Licensed in California in 1927. Doctor Merrill was a member of the Los Angeles County Medical Association.

MOFFITT, JOHN A. Died in Arcadia, September 24, 1958, aged 62, of carcinoma of the pancreas with metastasis. Graduate of the University of Louisville School of Medicine, Kentucky, 1921. Licensed in California in 1938. Doctor Moffitt was a member of the Los Angeles County Medical Association.

✤

SIEGEL, MORTON T. Died in Covina, September 14, 1958, aged 36, of heart disease. Graduate of Ohio State University College of Medicine, Columbus, 1951. Licensed in California in 1952. Doctor Siegel was a member of the Los Angeles County Medical Association.

✤

STEVENSON, ARTHUR P. Died in Torrance, September 27, 1958, aged 73. Graduate of Ensworth Medical College, St. Joseph, Missouri, 1907. Licensed in California in 1921. Doctor Stevenson was a retired member of the Los Angeles County Medical Association and the California Medical Association, and an associate member of the American Medical Association.

✤

THOMPSON, JOHN M. Died October 3, 1958, aged 47, of cancer. Graduate of the University of Cincinnati College of Medicine, Ohio, 1941. Licensed in California in 1947. Doctor Thompson was a member of the Los Angeles County Medical Association.